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Diagnosis Domestic Violence:

Making the Connection Between Violence and Health

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Diagnosis Domestic Violence:

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by

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Diagnosis Domestic Violence:

Making the Connection Between Violence and Health

by

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In the United States, domestic violence is a legal problem with profound health consequences. This paper explores the precise nature of those health consequences, which can be both long-term and short-term. In addition to causing physical and mental health problems, one of the ways that perpetrators of domestic violence exercise coercive control is by controlling their partners' access to healthcare. Reproductive coercion, an emerging focus of research and advocacy, is explored here as one manifestation of domestic violence. Because of the multifold ways that the legal and healthcare aspects of domestic violence are connected, a type of organization called a medical-legal partnership (MLP) is uniquely positioned to holistically aid survivors of domestic violence who need both legal and medical remedies.

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Introduction

Public health research indicates that up to 80 percent of an individual's overall health can be attributed to social and environmental factors. These factors, referred to as "social determinants of health," are commonly considered to include things like housing, education, and immigration status—circumstances that "are shaped by the distribution of money, power and resources at global, national, and local levels" and which are responsible for health inequities among different populations.[1]

This paper makes an argument for considering domestic violence as one such social determinant of health. Re-framing domestic violence as a health problem rather than solely as a legal problem, opens space to intervene to support survivors of domestic violence by leveraging medical knowledge and streamlining services. This re-framing is not an act of medicalizing an otherwise non-medical, purely social problem. Rather, it is a focusing of attention on the healthcare dimensions inherent in domestic violence.

Health and domestic violence intersect in ways that are complex and multifaceted. This paper seeks to unearth a deeper understanding of the linkages between health and domestic violence, with the thread running throughout that domestic violence advocacy can benefit from an understanding of the ways in which legal factors shape health outcomes.

First, this paper will consider domestic violence as a social determinant of health in that domestic violence is a legal and social phenomenon that results in adverse health outcomes for survivors. Second, this paper will examine the research that shows that control over a survivor's access to healthcare is one way that abusers perpetuate a coercive relationship dynamic. Finally, this paper will look at the potential for organizations called medical-legal partnerships (MLPs) to

[1] "Social Determinants of Health," World Health Organization, Last accessed April 28, 2020, https://www.who.int/social_ determinants/sdh_definition/en/.

effectively address domestic violence using medical remedies in tandem with legal remedies. The benefits of and challenges to implementing an MLP focused on the needs of domestic violence survivors will be explored, as well as the ways that MLPs can best be structured to promote survivor-centered, trauma-informed advocacy.

Chapter One: Health Consequences of Domestic Violence

The prevalence of domestic violence is staggering: the CDC estimates that one in three women over age fifteen has experienced domestic violence.[2] It is the leading cause of nonfatal injury to women in the United States.[3]

Domestic violence results in an array of health consequences for those who have experienced it. These health consequences, or morbidities, take two forms: those that have an immediate onset following an incident of violence and those that emerge only after a period of time has passed. These health effects can also be divided into those that impact the survivor's physical body and those that impact other aspects of well-being, such as emotional, psychological, or cognitive.

Immediate physical morbidity associated with domestic violence

Because domestic violence often has a physical component, it is common for people who have experienced domestic violence to present at healthcare facilities with physical injuries that are directly caused by the assaultive actions of an intimate partner.

[2] Kim Tingley, "Do Brain Injuries Affect Women Differently?" *New York Times* (June 26, 2019).
[3] Betsy McAlister Groves, et. al., "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," in *Poverty, Health, and Law: Readings and Cases for Medical-Legal Partnership,* ed. Elizabeth Tobin Tyler, 349. Durham: Carolina Academic Press, 2011.

The Bureau of Justice Statistics found that there is an annual average of over 500,000 assaults against women and over 100,000 against men, and about half of these result in physical injury.[4] A different study found that "more than one million women each year are estimated to seek medical care for injuries caused by battering resulting in 100,000 days of hospitalization, 30,000 emergency room visits, and 40,000 visits to doctors each year."[5]

Bruises, contusions, and abrasions are common among individuals who have experienced domestic violence, with common locations of the face, neck, upper torso, breast, or abdomen.[6] There are documented, telling patterns of physical injuries that could indicate that they were caused by a domestic abuser. A resource guide for medical-legal partnership practitioners notes that "characteristic bruise patterns may be seen on a victim's arms if she has attempted to defend herself."[7]

Strangulation is often present in domestic violence assaults. Strangulation, which is associated with various secondary physical aliments, has historically been under-diagnosed in survivors. Yet research on strangulation finds that "sixty percent of domestic violence victims are strangled at some point during the course of an abusive relationship."[8] Strangulation is particularly concerning as it is an indicator of potential lethality, with an investigator of domestic violence homicides concluding that "[s]trangulation turned out to greatly increase the chances of domestic violence homicide."[9]

Even in cases where strangulation does not lead to immediate death, the strangulation itself can pose severe health consequences. "Those strangled to the point of losing consciousness

[4] Marcus, "Screening for Abuse May Be Key to Ending It."
[5] Current Concepts in Women's Health: Domestic Violence and Primary Care, 1994, 7.
[6] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1157.
[7] Betsy McAlister Groves, et. al., "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," in *Poverty, Health, and Law: Readings and Cases for Medical-Legal Partnership,* ed. Elizabeth Tobin Tyler, 349. Durham: Carolina Academic Press, 2011.
[8] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 65.
[9] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 66.

are at their highest risk of dying in the first twenty-four to forty-eight hours after the incident from strokes, blood clots, or aspiration (choking on their own vomit)."[10] Even after the victim of the strangulation manages to survive the initial injury, there are also long-term morbidities associated with strangulation. Acts of strangulation "can cause brain injury—mild or traumatic—not only by cutting off oxygen to the brain, but because they are often accompanied by blunt force trauma to the head."[11]

The immediate health consequences of domestic violence—black eyes, broken limbs, and abrasions—are what most readily comes to mind when thinking about the injuries associated with domestic violence. Yet just as significant are those health consequences that are long-term or indirect.

Long-term physical morbidity associated with domestic violence

Domestic violence can result in severe, chronic, and long-term health problems, a finding made clear by Jacqueline Campbell, a nurse and prominent researcher on the health effects of domestic violence. [12]

Campbell finds that abused women have a 50 to 70 percent increase in gynecological, central nervous system, and stress-related problems.[13] She documents a range of physical health consequences that include:

- Central nervous system symptoms including headaches, back pain, fainting, or seizures;
- Illnesses associated with chronic fear and stress like GI disorders and appetite loss;
- Viral infections like cold and flu;
- Cardiac problems like hypertension and chest pain; and

[10] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 65.
[11] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 66.
[12] Jacqueline Campbell, et. al., "Intimate Partner Violence and Physical Health Consequences," (2002): 1157.
[13] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1157.

- GYN problems such as STDs, vaginal bleeding, fibroids, pelvic pain, and UTIs, all of which are associated with sexual abuse.[14]

In Campbell's research, of the women who were physically abused by their intimate partners, 40 to 45 percent also experienced sexual abuse.[15] Her research also found that the long-term negative health consequences for survivors can "translate into lower health status, lower quality of life, and higher utilization of health services."[16]

Non-physical and mental health morbidity associated with domestic violence

The fear and stress associated with having an abusive partner can result in less readily apparent health problems.[17] In particular, domestic violence has been found to be associated with increased levels of mental health disorders, such as depression and anxiety, as well as with substance use disorder. Evidence suggests that "women who are abused may turn to alcohol as a coping mechanism."[18] Experiencing domestic violence is also associated with increased incidence of post-traumatic stress disorder, "a condition experienced after a traumatic event in which the individual experiences repetitive, intrusive flashbacks, nightmares and anxiety symptoms that evoke the initial trauma."[19] The Texas Council on Family Violence found that 69 percent of Texas survivors who were interviewed met the diagnostic criteria for PTSD—exceeding the national rate of 50 percent.[20]

[14] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1158.
[15] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1158.
[16] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1157.
[17] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1158.
[18] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 348.
[19] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 350.
[20] "Creating a Safer Texas: Access to Safety, Justice, and Opportunity," Texas Council on Family Violence, 9, Last accessed April 28, 2020, www.tcfv.org.

Research on trauma and the body sheds new light on the various other health consequences experienced by some survivors of domestic violence. Rachel Louise Snyder writes that:

> A brain that reacts to being under constant attack will continue to send danger signals; increased levels of cortisol, adrenaline and other stress hormones, contributing to a vast constellation of physical and mental health issues. Dissociation is one of the most common issues, but victims of chronic domestic violence can also have a wide and long-term range of problems, from the emotional to the physical. They may have long-term cognitive loss, memory problems or sleep disorders. They may suffer from inattention or irritability. Some researchers link a host of physical ailments to unresolved trauma, including fibromyalgia and severe digestive issues.[21]

Domestic violence is rarely imagine to be the cause of this wide assortment of ailments.

Another important aspect of the health consequences of domestic violence is traumatic brain injuries (TBI) stemming from concussions or injuries to the head. While the bulk of research on TBI has been on football players and military service members, a recently published study found that as many as 31 million women might have had a TBI from a domestic violence incident.[22] This estimate is based on a study finding that three-quarters of women who were interviewed at domestic violence shelters had received at least one TBI.[23] Furthermore, in this study, it was found that half of the women who were interviewed had sustained multiple mild TBIs.[24] TBIs are problematic in part because the wide range of symptoms make them difficult to diagnose. For instance, concussion-related problems can include "persistent headaches, vertigo, cognitive impairment, personality changes, fatigue and difficulty performing ordinary daily activities."[25]

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[21] Rachel Louise Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us* (London: Bloomsbury Publishing, 2019) 263.
[22] Tingley, "Do Brain Injuries Affect Women Differently?" 2019.
[23] Tingley, "Do Brain Injuries Affect Women Differently?" 2019.
[24] Tingley, "Do Brain Injuries Affect Women Differently?" 2019.
[25] Tingley, "Do Brain Injuries Affect Women Differently?" 2019.

Rachel Louise Snyder, whose recent book on domestic violence was a national bestseller, notes the possible cognitive and behavioral impacts of domestic violence when she writes: "What researchers have learned from combat soldiers and football players and car accident victims is only now making its way into the domestic violence community: that the poor recall, the recanting, the changing details, along with other markers, like anxiety, hypervigilence, and headaches, can all be signs of TBI."[26]

However, despite these growing calls that the medical community needs to take seriously TBI and strangulation, it is still the case that domestic violence survivors are commonly not routinely screened for strangulation or brain injury, and "[t]his means that diagnoses are rarely formalized, the assaults and injuries are downplayed and abusers are prosecuted under lesser charges."[27] This quote demonstrates one of the consequences of failing to properly account for the injuries caused by domestic violence: the legal system's reliance on physical injuries as proof of domestic violence means that if a survivor's injuries are not documented by a healthcare professional and properly attributed to domestic violence, it will likely be more challenging for the survivor to arrive at a satisfactory legal solution.

Chapter Two: Healthcare-Related Abuse

While domestic violence is a frequent cause of adverse health outcomes, health and domestic violence are related in another way: controlling access to healthcare can be one of the ways that abuse is perpetrated. Abusers in relationships marked by domestic violence frequently use power and control to create a dynamic of coercion. Denying the survivor of domestic

[26] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 70.
[27] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 66.

violence a sense of bodily autonomy is one way that perpetrators of domestic violence are able to exercise control.

One way of diminishing a person's bodily autonomy is to restrict that person's ability to make choices about their healthcare. Healthcare-related abuse can take the form of restricting access to healthcare and medication, creating a powerlessness and dependency on an abusive partner. Healthcare-related abuse can also take the form of reproductive coercion.

Restricting access to healthcare and medication

Restricted access to health insurance as a mechanism of power and control can be thought of as one type of economic abuse, a situation in which an abuser controls the victim's financial life in order to create a sense of dependency and powerlessness. Particularly for women who are vulnerable because of a chronic medical condition or disability, being dependent on an abuser in order to retain health insurance can have a devastating impact.

Public policy plays a large role in this system of abuse: having a healthcare system that does not guarantee healthcare as a basic human right leaves room for these kinds of abuse to occur. Put differently:

> Abusers will use any weapon available to them. American health finance hands them a big one: domination of a survivor (and their children's) healthcare. Often, people who endure domestic violence will stay in the relationship, or stay in the home, because they or their children are financially dependent on their abuser—especially if they have chronic health conditions.[28]

Access to healthcare is rarely thought of as a domestic violence issue. Yet they are connected. In addition to threatening to cut off access to insurance coverage as a mechanism of power and control, some research has found that one tactic of abuse is for perpetrators of domestic violence

[28] Timothy Faust, *Health Justice Now: Single Payer and What Comes Next* (Brooklyn: Melville Press, 2019), 171.

to prevent their victim from taking medications. In one recent study, "[w]omen who said they had been abused within the past year were more likely to have partners who interfered with their medical care."[29]

If a victim's ability to leave the home is hampered by an abusive partner, even something as simple as making a visit to a doctor's office can be fraught. Indeed, research on this topic shows that abused women face difficulty just getting to doctor's appointments.[30]

Reproductive coercion

Reproductive coercion is a type of domestic violence. It entails limiting a victim's reproductive autonomy as a mechanism of power and control. One definition of reproductive coercion is that it is "behavior that interferes with the autonomous decision-making of a woman, with regards to reproductive health."[31] Another, narrower definition, is that it is "behavior by a male sexual partner to cause an unwanted pregnancy."[32] According to internal data, the Texas Council of Family Violence state that 42 percent of survivors in Texas experienced at least one type of reproductive coercion.[33]

Reproductive coercion was first identified in academic literature in 2010. A recent meta-analysis of the research about reproductive coercion found that there have been 27 studies published since 2010 that have specific findings related to reproductive coercion.[34] One, a study of high school students at a school-based health center, found that "[t]welve percent of females

[29] Marcus, "Screening for Abuse May Be Key to Ending It."
[30] Marcus, "Screening for Abuse May Be Key to Ending It."
[31] Karen Trister Grace, and Jocelyn C. Anderson, "Reproductive Coercion: A Systematic Review," *Trauma Violence Abuse* 19, no. 4 (October 2018): 371–390.
[32] Sharon J. Phillipsa, et al, "Reproductive coercion: an under-recognized challenge for primary care patients," *Family Practice* 33, no. 3 (2016): 286.
[33] "Creating a Safer Texas: Access to Safety, Justice, and Opportunity," Texas Council on Family Violence, 10, Last accessed April 28, 2020, www.tcfv.org.
[34] Trister, "Reproductive Coercion: A Systematic Review," X.

experienced recent reproductive coercion."[35] Another, a study that was drawn from research at primary care clinic in the Bronx, put the number at 24 percent.[36] The finding generated by the aggregate study was that the overall prevalence of reproductive coercion can be estimated at between 5-13 percent.[37]

The research design for most of these studies consist of anonymous, cross-sectional surveys of patients seeking medical care. The survey used in the study based in a primary care clinic consisted of the following questions, administered privately to patients who were waiting for their appointments:

> (1) Has a sexual partner ever told you not to use birth control?
> (2) Has a sexual partner ever said he would leave you if you did not get pregnant?
> (3) Has a sexual partner ever taken off the condom or broken a condom on purpose while you were having sex so that you would get pregnant?
> (4) Has a sexual partner ever taken your birth control (such as pills) or prevented you from going to the clinic to get birth control, so that you would get pregnant?
> (5) Has a sexual partner ever made you have sex without a condom so that you would get pregnant?

This series of questions, known as the Miller Questionnaire, has been used several times by different researchers. For the primary care clinic study, an affirmative answer to any one of the survey questions led researchers to code the respondent as having experienced reproductive coercion. These survey questions also serve to show specific examples of reproductive coercion that have been identified by researchers as mostly likely to occur. The study of primary care patients ends with general advice that "[p]hysicians, and/or staff in the practice, should consider initiating a conversation about [reproductive coercion] with their patients."[38] However, the

[35] Reproductive Coercion and Relationship Abuse Among Adolescents and Young Women Seeking Care at School Health Centers. 351
[36] Phillipsa, "Reproductive coercion: an under-recognized challenge for primary care patients," 286.
[37] Trister, "Reproductive Coercion: A Systematic Review," 6.
[38] Phillipsa, "Reproductive coercion: an under-recognized challenge for primary care patients," 289.

researchers do not specifically advise on how healthcare providers should approach these conversations about sensitive topics such as abuse and coercion.

Other studies of reproductive coercion end with similar recommendations for reproductive coercion to be discussed with patients in the clinical setting. The school-based health study states that the end practice goal would be for "routine inquiry [about] these exposures [to] be integrated into every clinical encounter."[39] The meta-analysis concludes that "[a]ssociations between [intimate partner violence] and reproductive coercion offer opportunities for collaboration between healthcare and violence-related service providers,"[40] and that "[r]eproductive coercion should be included in discussion regarding legal definitions of sexual and IPV."[41]

Yet the studies do not address how healthcare providers should go about having these conversations, or how the legal framework regarding domestic violence might shift in light of new realizations about reproductive coercion. The medical-legal partnership is one example of a structure that could foster conversations about reproductive coercion and domestic violence in the clinical setting.

Chapter Three: Medical-Legal Partnerships

In the United States, for at least the past 50 years, domestic violence has largely been regarded as an individual legal problem. Yet this conceptualization of domestic violence arguably relies too much on a punitive legal system to solve the problem of domestic violence.[42]

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[39] Hill, et al, "Reproductive Coercion and Relationship Abuse Among Adolescents and Young Women Seeking Care at School Health Centers," *Obstetrics & Gynecology* 134, no. 2 (August 2019): 351-359.

[40] Trister, "Reproductive Coercion: A Systematic Review," 34.

[41] Trister, "Reproductive Coercion: A Systematic Review," 34.

[42] Leigh Goodmark, Law Is the Answer - Do We Know That for Sure: Questioning the Efficacy of Legal Interventions for Battered Women, 23 *St. Louis U. Pub. L. Rev.* 23 (2004): 7.

In addition, viewing domestic violence primarily as a legal problem neglects its healthcare dimensions.

As this paper has shown, domestic violence is a healthcare issue as well as a legal issue. Because of that, it makes sense for legal providers to work in conjunction with healthcare providers to meet the needs of domestic violence survivors. One model that would allow this kind of collaboration to happen is the medical-legal partnership (MLP).

MLPs are structured so that a legal services provider is embedded within the healthcare team. There are at least five distinct potential benefits to using MLPs to work with survivors of domestic violence. MLPs in this context could:

(1) Utilize the referral system of clinics, providing access to legal advice and legal remedies to domestic violence survivors who wouldn't otherwise seek them out;

(2) Provide direct legal assistance to patients at clinics, resulting in an overall healthier patient population;

(3) Cultivate attorney-physician collaboration to provide more robust assistance to meet the needs of survivors of domestic violence;

(4) Effectuate clinical policy transformation so that the healthcare setting can better meet the needs of survivors of domestic violence; and

(5) Use patient-to-policy advocacy as a means of affecting broader, systemic changes that will indirectly benefit survivors of domestic violence.

The remainder of this paper will explore these potential benefits, as well as some potential challenges, that might be applicable to an MLP focused on meeting both the health and legal needs of survivors of domestic violence.

Medical-Legal Partnerships as referral systems

Survivors of domestic violence need access to healthcare services when they have been physically injured. Sometimes, they also need legal advocates who can help them with the common legal remedies of requesting a protective order, engaging in custody disputes, filing for divorce, or filing a criminal offense report. Navigating the dual systems of healthcare and legal services can be overwhelming, especially for low-income survivors and other marginalized groups.

One benefit to having attorneys co-located with physicians is that the process of getting help is streamlined for people when they only have to make one appointment and go to one location. The increased logistical ease makes it more likely that survivors of domestic violence will seek out the help of attorneys when they present with an injury caused by domestic violence.

Research supports the proposition that clinics should proactively address domestic violence among their patient populations. Campbell's study of the health consequences of domestic violence concludes with the advice that patients receive "routine universal screening and sensitive in-depth assessment of women presenting with medical complaints related to domestic violence."[43] The Institutes of Medicine,[44] the U.S. Preventative Series Task Force,[45] and the Department of Health and Human Services[46] have all recommended that adolescent and adult women be screened and counseled for domestic violence as part of preventative care.

[43] Campbell, "Intimate Partner Violence and Physical Health Consequences," 1157.
[44] Institute of Medicine (IOM). Clinical preventive services for women: Closing the gaps. Washington, DC: The National Academies Press, 2011.
[45] Nelson HD, Bougatsos C, Blazinaq I. Screening women for intimate partner violence in healthcare settings: A systematic review to update the U.S. Preventive Services Task Force recommendation. Ann Intern Med 2012;156:796–808.
[46] Health Resources and Services Administration (HRSA). Women's preventive health services: Required health plan coverage guidelines. Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services, 2012. https://www.hrsa.gov/womens-guidelines/index.html.

Just as a patient with heart pains could get a referral to a cardiologist, a patient who is experiencing domestic violence could get a referral from her doctor to visit the clinic's MLP lawyer. But unless the patient divulges to the physician information about domestic violence, the doctor might not know to make the referral. In fact, one study found that only 7 percent of women reported that they had ever been asked about domestic violence at a doctor's appointment.[47] This indicates a need for more and better training about domestic violence among healthcare providers.

In terms of how a domestic violence-focused MLP's referral system might work, domestic violence could be assessed among a patient population either through disclosure, pattern recognition, or assessment tools.[48] At least 13 different screening tools exist for identifying survivors of domestic violence in the healthcare setting.[49] One representative diagnostic tool currently in use is the STaT: Screen for Lifetime IPV. This tool consists of three questions:

> (1) Have you been in a relationship where your partner has pushed and slapped you?
> (2) Have you ever been in a relationship where your partner threatened you with violence? and
> (3) Have you ever been in a relationship where your partner has thrown, broken and punched things?[50]

These three simple questions have been shown to be effective at determining whether someone is in a domestic violence relationship, using language that is clear and non-stigmatizing.

An existing MLP that serves domestic violence survivors is the Lancaster Medical-Legal Partnership for Families in Pennsylvania. This MLP developed an IPV Assessment

[47] Erin N. Marcus, "Screening for Abuse May Be Key to Ending It," *New York Times* (May 20, 2008).

[48] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 350.
[49] Annie Lewis-O'Connor, et al, "The state of the science on trauma inquiry," *Women's Health* 15: (August 2019).
[50] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 351.

Documentation Form and a DV Resources Information Card.[51] The assessment form is distributed to all healthcare providers and is laminated. It is completed in erasable marker during the patient visit and consists of questions similar to the STaT that are designed to assess if someone is experiencing domestic violence. A positive score on the assessment—indicating that the patient might be experiencing domestic violence—is noted in the patient's medical file. The original assessment is erased. The patient is then given the DV Resources Card, which has the information for setting up an appointment with the MLP's attorney.

However, even with diagnostic tools and a fully-trained MLP onsite, it may still be challenging to identify patients who are experiencing domestic violence. This can be because "in a primary care setting . . . there may be no physical symptoms of abuse, but rather a cluster of symptoms or 'red flags' that raise the physician's index of suspicion."[52] It can also be because the shame and fear associated with disclosing domestic violence can lead a victim of domestic violence to keep this information secret.

Medical-Legal Partnerships as providers of direct legal services

The battered women's movement that emerged in the 1960s and 70s had the explicit aim of working within the law to make domestic violence a criminal offense, replete with legal remedies (protective orders, crime victim's compensation, custody preference) for victims and legal repercussions (arrest, incarceration) for perpetrators. This conceptualization of domestic violence as primarily a legal problem was underscored by 1994's Violence Against Women Act,

[51] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 361.
[52] Current Concepts in Women's Health: Domestic Violence and Primary Care, 1994, 21.

which allotted millions of dollars in federal funds for legal assistance for survivors of domestic violence.[53]

Protective orders can be incredibly useful tools for survivors of domestic violence, as perpetrators of domestic violence who violate the terms of the order face criminal repercussions. Other legal protections for survivors of domestic violence—such as the rebuttable presumption in the Texas Family Code that perpetrators of domestic violence do not receive managing conservatorship—are also useful and important.[54]

However, as the staggering persistence of domestic violence shows, this response has been insufficient. One reason the response has been insufficient is many victims are not identified and cannot access the legal tools available. Relying on law enforcement to keep domestic violence survivors safe excludes survivors who are reluctant to engage with law enforcement because of fears of racialized violence by the police or fears of deportation over citizenship status. A purely legal response to domestic violence misses opportunities to engage with healthcare providers to address the problem.

A lawyer working in a clinic with people who have experienced domestic violence could provide many of the same legal services as a lawyer working in a conventional legal setting. The MLP lawyer could help the patient with safety planning, inform the patient about her legal rights, or represent them in a legal proceeding. These legal remedies would be enhanced by the lawyer's access to the patient's medical records. Often medical documentation is among the most persuasive evidence that will convince a court to grant a protective order or rule favorably in a custody case. Simply having access to a patient's medical file, and to the healthcare providers

[53] "History of VAWA," Legal Momentum, Last accessed April 28, 2020, https://www.legalmomentum.org/history-vawa.
[54] Texas Family Code § 153.004(b) (1995).

who treated the patient, can increase a lawyer's chances of securing the desired legal outcome for a client.

For these reasons, "[m]edical-legal partnerships are uniquely positioned to address safety issues for families experiencing violence and ensure that they have access to legal and social services that help them stay safe."[55] Yet the lawyer's advocacy with the client could also go above and beyond the procurement of legal remedies.

Medical-Legal Partnerships as sites of attorney-physician collaboration

The MLP model features lawyers as part of the healthcare team. This has several benefits. It potentially reduces the need for survivors to have to tell their abuse to multiple parties in order to get assistance, an experience that could be re-traumatizing.

An MLP that is attuned to the needs of survivors could also aid domestic violence survivors who would otherwise not receive much-needed legal protections. "Healthcare providers are often on the front lines of identifying and addressing family violence." Because "their regular contact and close relationships with people put them in a unique position to screen for and identify patients and families experiencing violence,"[56] it is likely that healthcare providers who know to refer patients to an onsite MLP could result in a more comprehensive response to the needs of domestic violence survivors.

In addition to streamlining the process for a survivor to access healthcare and legal services, an MLP could capitalize on the trust that patients have with their healthcare providers. Domestic violence can be a lonely and stigmatizing experience. Even in the wake of the Me Too

[55] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 345.
[56] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 345.

movement, which has increased awareness of assault and abuse, survivors of domestic violence can still face judgment and criticism when "coming out" about being in an abusive relationship.

Because healthcare providers are endowed with a large amount of social trust, it is possible that a doctor asking about sensitive topics like domestic violence may result in a patient disclosing this information. Having a lawyer in these space could build on the trust that exists between patients and clinics. In the words of one survivor who was quoted in an article on screening for abuse in the doctor's office, "The doctor's office is a good place to go because it's neutral and it's confidential. It's not like telling your husband you're going to the police department."[57]

Medical-Legal Partnerships as leaders of clinical policy transformation

An extension of the collaboration between attorneys and physicians could be the impact of an MLP on the broader clinical environment. Onsite MLPs that are attuned to patient's social realities and legal needs can aid clinics as a whole in establishing policies around working with survivors that are trauma-informed and in line with best practices around safety.

MLPs can provide leadership to clinics about being trauma-informed and aware of how violence at home might be impacting a patient's experience in the clinic. Trauma is defined as

> an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[58]

Many, if not all, survivors of domestic violence have gone through traumatic experiences. For both attorneys and healthcare providers, being sensitive to the ways that trauma might be

[57] Marcus, "Screening for Abuse May Be Key to Ending It."
[58] "Trauma-informed approach and trauma-specific interventions," Substance Abuse and Mental Health Services Administration (SAMHSA), Last accessed April 28, 2020, https://www.samhsa.gov/nctic/trauma-interventions.

impacting the lived experience of this group of patient-clients could be important in establishing trust and resulting in survivor-driven advocacy.

MLPs could also aid clinics in thinking about the unique safety considerations of patients who have family violence at home. When screening for domestic violence or assisting someone who is experiencing domestic violence, safety concerns are paramount. "When a victim reveals IPV to a healthcare provider or lawyer, the immediate concern should be ensuring the safety of the victim and her children."[59] Following this, the healthcare provider "should interview carefully, assess for danger, and respect the patient's right for autonomy and decision making."[60] While there is great potential for having healthcare practitioners screen for domestic violence and refer the patient to an MLP, this process must be implemented in a way that prioritizes patient safety and autonomy. Knowing that an MLP attorney is onsite to help with a patient's legal needs might make clinics more comfortable about asking screening patients for family violence.

Medical-Legal Partnerships as community advocates

Based on needs of clients, MLPs can advocate for national, state, and local policies that will benefit the legal well-being of the people in the community. Many MLPs explicitly define their mission to include work that connects the needs of client-patients to policies that will benefit them. For instance, one of the items on Philadelphia's Nursing-Legal Partnership's policy agenda is to "Improve Job Stability and Employment Conditions for Low-Wage Workers."[61] The Nursing-Legal Partnership's work on this involved lobbying the city to pass the Fair Workweek

[59] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 361.
[60] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 351.
[61] "Policy Agenda 2019-2020," Nursing-Legal Partnership, Last accessed April 28, 2020, https://nurseledcare.phmc.org/programs/nursing-legal-partnership.html.

Employment Standards Bill, which went into effect in January 2020, and which required employers to give workers advance notice of their work schedules. This better allowed working parents to balance the demands of work and childcare.[62]

During the last Texas legislative session, there was proposed legislation around making it easier for survivors of domestic violence to terminate leases and making a protocol to require perpetrators of domestic violence to surrender their guns.[63] An MLP that worked with survivors of domestic violence could be an important part of the lobbying efforts to pass these specific bills by sharing the stories of patient-clients to policymakers and the public.

In Texas, there is growing momentum for the health effects of domestic violence to be address on a state-wide level. For instance, one of the planks of the Texas Council on Family Violence (TCFV)'s Legislative Agenda in 2019 was on family violence and health care. Stating their support for legislative attention to this issue, TCFV wrote:

> Increasingly policy makers have realized that the susceptibility of a victim to experiencing intimate partner violence is a matter of health. In Texas, this point of view represents a new direction for both those involved in health care and those that advocate against family violence. This measure would create a legislatively mandated, non-funded task force comprised of public and private subject matter experts to look more closely at this important overlap and then offer consensus-based policy recommendations moving forward.[64]

Specifically for this type of policy action, MLPs could provide valuable support.

Anticipated Challenges

While MLPs pose many possibilities for addressing domestic violence, there are also some distinct challenges associated with implementing this kind of MLP.

[62] Stephanie Wykstra. "The movement to make workers' schedules more humane." *Vox*, (Nov. 5, 2019).
[63] Tracey Grinstead-Everly, "86th Texas Legislative Session Preview" Texas Council on Family Violence, Last accessed April 28, 2020. www.tcfv.org.
[64] Grinstead-Everly, "86th Texas Legislative Session Preview."

One challenge is possible reluctance on the part of healthcare providers to delve into issues related to domestic violence with a patient. For example, "some physicians see domestic violence primarily as a criminal justice issue, and take umbrage at being expected to delve into a difficult, messy topic when they already have to screen for many other conditions and diagnose complicated diseases in the span of an ever-shorter visit."[65]

This mindset can be mitigated by having MLP attorneys, social workers, and/or advocates onsite to help patients who are experiencing domestic violence. That way, doctors do not feel overwhelmed with the responsibility of having to care for all the patient's domestic violence concerns.

In addition, all medical staff who are assessing and working with patients experiencing domestic violence should be thoroughly trained. For instance, medical staff should understand the difference between partner conflict or disagreement and the "coercive, control-based intimidation or violence that characterizes IPV."[66]

Another challenge can take the shape of reluctance on the part of the patient to seek help for what might be viewed as a "non-medical" issue at the doctor's office. This can happen for a variety of reasons, including:

- Fear of retaliation by the batterer;
- Fear of rejection, of not being believed or of being told she is responsible for the abuse;
- Minimization or denial of the injuries leading to a belief that they are not serious enough to mention;
- Fear of losing the financial support of the batterer;
- Lack of knowledge of available resources or mechanisms for help;
- Fear of being judge by the physician and losing his or her respect; and
- Fear of losing her children if she is viewed as a neglectful mother.[67]

[65] Marcus, "Screening for Abuse May Be Key to Ending It."
[66] Groves, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems," 347.
[67] Current Concepts in Women's Health: Domestic Violence and Primary Care, 1994, 19.

It is important for MLP staff to understand that these factors are legitimate and that they might be motivating a patient's desire to decline additional legal help for a domestic violence issue. What is critical is for the patient to have autonomy in her decision-making and support from the MLP staff.

And while the challenges associated with implementing an MLP are real, it is also important to keep in mind the risks of *not* identifying and addressing domestic violence. As Rachel Louise Snyder writes:

> Many victims spend their lives grappling with the consequences of an unseen, undiagnosed, untreated, unsupported injury in which the narrative almost inevitably turns hostile—that they are crazy, or somehow that they are to blame.[68]

Implementing an effective, trauma-informed MLP to address the needs of survivors of domestic violence is difficult, but certainly worthwhile.

Conclusion

The past 40 years have produced a profound change in how domestic violence is regarded. No longer is it acceptable for a person to be abused by an intimate partner. Yet the expansive harms caused by domestic violence are still not fully recognized. Doctors and nurses need to treat the whole patient—not just the patient's broken bone, but the abusive partner causing the broken bone. Not just the patient's depression, but the violence in her life that is resulting in acute stress and hopelessness.

The legal remedies that lawyers use to treat domestic violence—protective orders, criminal charges, custody and divorce lawsuits—can be paired with health remedies to be made

[68] Snyder, *No Visible Bruises: What We Don't Know About Domestic Violence Can Kill Us*, 69.

more effective for survivors of domestic violence. One such example of this kind of interdisciplinary cross-collaboration is the medical-legal partnership. Equipping healthcare professionals to recognize the signs of domestic violence and legal service providers to recognize the ways that their legal remedies can be more powerful when aided by healthcare professionals will result in more effective advocacy for people subject to violence in the home.

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